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THOMAS L. GARTHWAITE, M.D.
Director and Chief Medical Officer

FRED LEAF
Chief Operating Officer

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES
313 N. Figueroa, Los Angeles, CA 90012
(213) 240-8101

April 18, 2005

TO: Each Supervisor

FROM: Thomas L. Garthwaite, M.D.
Director and Chief Medical Officer

Kae Robertson
Managing Director
Navigant Consulting, Inc.

SUBJECT: KING/DREW MEDICAL CENTER ACTIVITY REPORT – WEEK ENDING APRIL 15, 2005

This is to provide you with an activity report for the week ending April 15, 2005 for King/Drew Medical Center (KDMC). This report details activities conducted by the Director of the Department of Health Services (DHS) and Navigant Consulting, Inc. Please let us know if you have questions.

DHS DIRECTOR

- Met with KDMC non-clinical department leadership and emphasized the importance of paying attention to all the details of their jobs in order to meet accreditation standards and the seriousness of the current challenges confronting the institution.

- Met with all clinical department chairs and discussed my expectations regarding supervision of residents and communication of adverse events. Emphasized the critical importance of documentation in the clinical record of their involvement in care.

- Participated with Navigant executive leaders in the weekly KDMC oversight meeting to review current issues, operations, clinical affairs, and academic matters.

- Met with KDMC Medical Administration leadership to review their progress in addressing physician issues. Scheduled comprehensive reviews of each clinical department starting the week of April 18, 2005. These evaluations will consist of two hour reviews of workload, schedules, residency programs, budgets, and other issues.

- Discussed strategies with Drew University for accelerating recruitment of key Department Chairs and interviewed the leading candidate for a major Department.

- Toured the emergency room twice, the Intensive Care Units twice, and the Pediatric Intensive Care Unit, Critical Care Unit, and telemetry and psychiatric areas once.

- Expedited the request for radio transmitters for telemetry unit. Reviewed justification and selection of proposed vendor.

- Reviewed perceived delays in Psychiatry unit remodeling and determined that work is on schedule and relayed information to staff.

- Met with entire Navigant team at the end of each day to listen to daily issues and progress.

- Initiated discussions with Drew University and County Counsel to explore the establishment of a single executive for KDMC and Drew University.

NAVIGANT CONSULTING, INC.

- ***Pressing Issues***

  - Psychiatry physician weekend staffing.
  - Case reviews by the Centers for Medicare and Medicaid Services and California Department of Health Services.
  - Pharmacy security cameras.

- ***Progress Made in KDMC Quality Turnaround Plan***

  - KDMC Medical Administration leadership met with clinical department chairs to delineate higher expectations for participation in care, closer resident supervision, and documentation by attending physicians (see attachment). Results are already being seen. For example, during the insertion of an endotracheal tube on the evening shift the attending physician was noted to arrive and provide supervision. A resident remained to provide one-to-one medical care for an unstable patient until there was an Intensive Care Unit bed available.

  - KDMC Medical Administration leadership met with the Chair of the Emergency Department to delineate higher expectations for resident oversight, review of triage patients, and documentation by attending physicians.

  - Revised physician on-call schedule format and developed an audit process to test physician response.

  - Eliminated block scheduling in the surgical clinic. Eliminated shadow charts in the surgical clinic. Anecdotally, the waiting room is not as crowded and patient flow

improved. Based on this success appointment scheduling will be implemented for other outpatient clinics.

- All Registered Pharmacists who failed the general competence section (math) of the American Society of Hospital Pharmacists test passed the re-test.
- No unexpected deaths month-to-date.

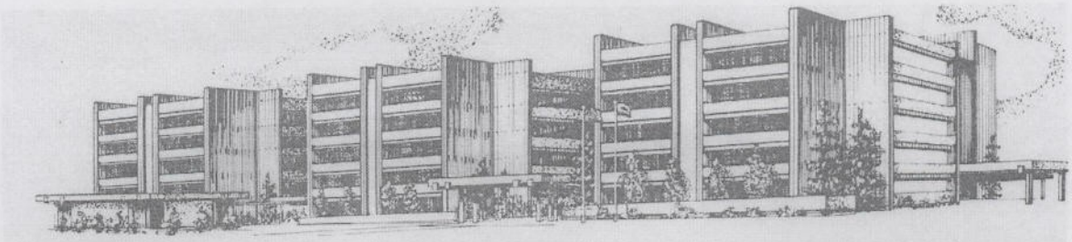
- ***Barriers Encountered in KDMC Quality Turnaround Plan***
  - Referred 14 nursing and physician cases to DHR for personnel actions this week.
  - Terminated one nursing and one physician contractor for poor performance.
  - One potential sentinel event month-to-date.

Please let us know if you have any questions.

TLG:KR:mm

Attachment

c: Chief Executive Officer
County Counsel
Executive Officer, Board of Supervisors



MARTIN LUTHER KING, JR./CHARLES R. DREW MEDICAL CENTER 12021 South Wilmington Avenue Los Angeles, CA 90059 310/66

April 13, 2005

To: Emergency Medicine Department Faculty

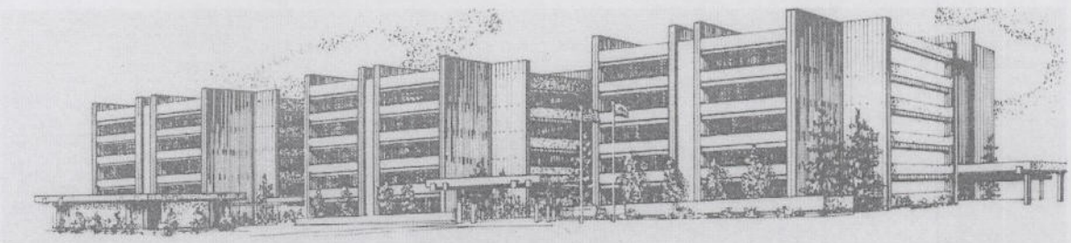
From: Roger A. Peeks, M.D.
Medical Director

Subject: Clinical Crisis

The care we deliver is currently under close scrutiny and even the perception of lapses in care can be terribly damaging to the medical center. To avoid this, I have written a memo to all members of the PSA asking all attendings to be more involved in patient care and housestaff supervision. In addition, I have a few specific things that I would like to ask the ED attendings to do. Effective immediately:

- All level 1 patients must be seen by an attending within 30 minutes.
- All level 2 patients must be seen by an attending within 60 minutes.
- All level 3-5 patients must be seen by an attending prior to discharge.
- Any patient with a change in level must be seen by an attending within the time frame above for the new level.
- Attendings must round on all patients with the housestaff every 6 hours.
- Attendings must consult with the Triage Nurse twice per shift and upon request review the status of patients waiting to be seen.
- Attending involvement must be documented with a note in the chart that must be legible, timed, dated, and contain the attending physician's signature and identification stamp.

/vlr



MARTIN LUTHER KING, JR./CHARLES R. DREW MEDICAL CENTER 12021 South Wilmington Avenue Los Angeles, CA 90059 310/66

April 13, 2005

To: PSA members

From: Roger A. Peeks, M.D.
Medical Director

Subject: Clinical Crisis

Once again, we find ourselves under the microscope with the care we give being closely scrutinized. The survival of the medical center is seriously jeopardized by lapses in care. Even the perception of such can be damaging.

The medical staff is ultimately responsible for the care of our patients and in this atmosphere we may have to go even beyond community standards to demonstrate that we are doing everything that we can to deliver the best care possible. To help ensure this, I am asking all of you to be even more involved in the care of your patients and the supervision of the housestaff.

The following measures are designed to make sure that the attendings are appropriately involved and that their involvement is clearly documented in the chart. This will benefit our patients and housestaff training. Effective immediately:

- All patients admitted to the hospital must have an attending admitting note in the chart within 24 hours of admission. That note must contain, at a minimum, pertinent history, pertinent findings from the physical examination, an assessment, and plans.

- Attendings must make rounds, with housestaff on teaching services, on patients in critical care areas at least twice per day and document both encounters with a note in the chart.

- Attendings must make rounds, with housestaff on teaching services, on all other patients every morning and write an attending note in each chart at least once per day.

- On services with residents, attendings must make contact with residents in the evening before leaving. Patients that are unstable must be seen in the evening and those encounters must be documented with a note in the chart.

- In addition, attendings must see patients whenever requested by the residents, physician assistants or nurses.

- Any patient whose clinical condition deteriorates requiring a higher level of care (e.g., floor patient requiring intermediate or critical care) must be seen by an attending within 30 minutes of being called. A note must be placed in the chart to document that encounter.

- An attending note must include an interval relevant history, appropriate physical examination, an assessment and a plan.

- All notes must be legible, timed, dated, and contain the attending physician's signature and identification stamp.

- Random chart audits will be performed and corrective action will be taken when necessary.

RP:vlr

COUNTY OF LOS ANGELES
DEPARTMENT OF AUDITOR-CONTROLLER

KENNETH HAHN HALL OF ADMINISTRATION
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J. TYLER McCAULEY
AUDITOR-CONTROLLER

May 10, 2005

TO: Supervisor Gloria Molina, Chair
Supervisor Yvonne B. Burke
Supervisor Zev Yaroslavsky
Supervisor Don Knabe
Supervisor Michael D. Antonovich

FROM: J. Tyler McCauley
Auditor-Controller

SUBJECT: **UTILIZATION AND OVERSIGHT OF PHYSICIAN SERVICES CONTRACTS – DEPARTMENT OF HEALTH SERVICES**

On April 26, 2005, your Board directed the Auditor-Controller to review the utilization of physician services contracts to ensure that there is appropriate oversight by clinical administration. This review was requested after the Los Angeles Times reported questionable payments in excess of $1.3 million to a contract Radiologist at Martin Luther King Jr./Drew Medical Center (KDMC). This report summarizes our findings and suggestions for strengthening controls over contractor timekeeping.

Background

The Department of Health Services (DHS) contracts with a variety of specialty medical services providers to meet patient care requirements and address staffing shortages in various areas of clinical expertise at County hospitals and ambulatory care centers. Contract physicians are hired under specialty medical services agreements, executed between DHS and physician referral services or individual doctors. These registry agreements also delegate authority to the DHS Director to execute additional contracts, on an as needed basis, to engage new providers throughout the contract term.

Individual "Proposition A" and exempt services agreements are also executed with physician specialists as needed to meet staffing requirements. Contract physicians are paid an hourly rate based on field of practice, as detailed in each doctor's respective contract. As of the date of this report, DHS has approximately 250 active Proposition A and exempt contracts.

Scope

The purpose of our review was to determine the level and scope of contract physician utilization by DHS facilities, and to document and analyze the system of controls in place to monitor these professional services agreements. To determine utilization, we compiled and reviewed transaction and payment information and other supporting documents, and scheduled work hours for each participant in our sample population.

Our analysis determined that Martin Luther King, Jr./Drew Medical Center (KDMC) had the highest utilization of contract physician services, measured by total expenditures, for the current Fiscal Year-to-date (the period of our review). Therefore, we focused our review on KDMC providers. This included a sample of registry physicians and Proposition A and exempt doctors. Services provided under the Affiliation Agreement with Drew University were not included in this review.

To determine DHS' oversight of these contracts, we examined policies, procedures and internal controls pertaining to the review and approval of invoices for contract services. We also interviewed DHS managers and staff, and KDMC administrators responsible for processing invoices and ensuring compliance with contract terms. In addition, we spoke with an executive from Reliable, and compared activity/productivity records for a sample of KDMC faculty and contractors.

Summary and Conclusions

Overall, we believe that there is a legitimate need for contract physicians to meet staffing demands and to provide necessary care and services to patients at KDMC. However, one of the most significant obstacles to effective oversight of specialty medical services agreements is the absence of independent verification that contract doctors were actually present when they claimed to be working. The importance of such verification is increased by findings that some doctors have private practices or other secondary employment outside the County, which could result in hours not worked at County hospitals being billed to the County if working hours are not closely monitored. This problem is further compounded by the absence of any express requirement that contractors report outside employment activity.

We have recommended that DHS immediately establish more meaningful controls over contractor work hours and require contract physicians to disclose outside business/employment activity as a term of their agreements. Specifically, DHS should immediately direct hospital managers to require that contract physicians obtain independent verification they were present when scheduled. This could be accomplished by the hospital designating an employee, who was actually present when the contractor was working, provide an approving signature on each claim. To the extent possible, the authorizing employee should be in a position to observe the contractor's performance.

We appreciate the assistance of DHS staff in completing this review. Please call me or have your staff contact Marion Romeis at (626) 293-1400 if you have questions.

R-2005-0457-E.DOC
JTM:MR:RC

c: David E. Janssen, Chief Administrative Officer
Department of Health Services
Thomas L. Garthwaite, M.D., Director and Chief Medical Officer
Fred Leaf, Chief Operating Officer
Roger Peeks, M.D., Medical Director, KDMC
Violet Varona-Lukens, Executive Officer
Audit Committee Members
Public Information Office

Department of Health Services
Utilization and Oversight of Physician Services Contracts

Background

The Department of Health Services (DHS) contracts with a variety of specialty medical services providers to meet patient care requirements and address staffing shortages in various areas of clinical expertise at County hospitals and ambulatory care centers. Several factors influence the demand for contract medical professionals, including a reluctance by medical professionals (particularly specialists in areas of high private sector demand) to accept "below-market" salaries, and the resignation/retirement of existing hospital faculty for which the Department cannot find or hire replacements.

Contract physicians are hired under specialty medical services agreements, executed between DHS and physician referral services (registry providers) or individual doctors. Current five-year agreements with Reliable Heath Care Services (Reliable) and USC Radiology Associates were approved by the Board of Supervisors on June 15, 2004. Anesthesia Provider Group (APG) has a similar contract that was approved by the Board on June 5, 2001. These agreements provide for specialty medical services, and delegate authority to the DHS Director to execute additional contracts, on an as needed basis, to engage new providers throughout the contract term.

Individual "Proposition A" and exempt services agreements are also executed with physician specialists as needed to meet staffing requirements. As approved by the Board on June 29, 2004, these agreements are exempt from a formal bidding or competitive negotiation process, and with respect to physicians are limited to certified practitioners in a "specialty" field recognized by the American Medical Association (AMA). Contract physicians are paid an hourly rate based on field of practice, as detailed in each doctor's respective contract. Exempt agreements are also subject to an annual maximum of 1,681 hours. As of the date of this report, DHS has approximately 250 active Proposition A and exempt contracts.

Scope

The purpose of our review was to determine the level and scope of contract physician utilization by DHS facilities, and to document and analyze the system of controls in place to monitor these professional services agreements. To determine utilization, we compiled and reviewed transaction and payment information from the Countywide Accounting and Purchasing System (CAPS), and physician contracts, timesheets, invoices, and other supporting documents provided by Department management.

Our analysis determined that Martin Luther King, Jr./Drew Medical Center (KDMC) had the highest utilization of contract physician services, measured by total expenditures, for the current Fiscal Year-to-date (the period of our review). As a result, we focused our transaction-level test work on KDMC providers. This included a review of registry physicians from Reliable and APG, and a sample of ten Proposition A and exempt physician contracts. Services provided under the Affiliation Agreement with Drew University were outside the scope of this review, and were not included in our test work.

To determine DHS' oversight of specialty medical services agreements, we examined Department and hospital policies, procedures and internal controls pertaining to the review and approval of invoices for contract services. We also interviewed DHS managers and staff, and KDMC administrators responsible for processing invoices and ensuring compliance with contract terms. In addition, we spoke with an executive from Reliable and documented their protocols for invoicing, billing and supervising contract physicians.

While we could readily obtain the time sheets, invoices, and accounting documents necessary to perform a comparative/analytical review of contract physician utilization, many of the contractor hours billed the County were certified by clinical administrators who were not physically present when the contractor claimed to be working. While we did not find any cases in our sample population where we could prove that time was improperly recorded, this lack of direct verification calls into question the reliability of such time records. Regardless, we had no other options for obtaining this information other than to rely on the documents certified by KDMC administrators. Recommendations for improving controls over contractor and staff attendance are included in the Oversight and Control Procedures section of this report.

Findings

Overall, it appears that contract physicians are being utilized to meet legitimate staffing needs and to provide necessary care and services to patients at the Department's hospitals and health centers. We noted that utilization, particularly at KDMC, has increased with the termination of their resident radiology program, as would be expected.

While there appears to be a legitimate need for contract physician services, we identified some questionable business practices and controls over the administration of specialty medical services agreements that the Department should immediately address. These include the lack of direct verification for many contractor and faculty work hours, and the absence of a requirement that contractors report outside employment activity. These deficiencies likely contributed to the circumstances that resulted in one contract employee billing more than $1.3 million for professional services during a twelve month period, including a number of consecutive twenty-four hour shifts.

Utilization

For the period of our review, DHS paid Reliable more than $8.5 million for various professional services. Of that total, approximately $5.6 million (66%) was for services provided to KDMC, and more than $3 million of that amount (54%) was for physician services (radiologists), including the contract physician identified . During the same period, DHS paid $2.7 million to APG for professional services, of which $1.5 million (56%) was billed to KDMC. An additional $2.5 million was paid directly to independent physician contractors under Proposition A and exempt agreements for services at KDMC.

We conducted a detailed analysis of hours and shifts worked for the nine most highly compensated Proposition A and exempt physician contractors, and more than half of all Reliable and APG doctors who billed KDMC for services between July 1, 2004 and May 1, 2005. While our review did not identify any contractors who claimed to have worked as many hours as the contract physician named by The Los Angeles Times, we did find many instances where contractors billed for at least 18 consecutive hours of work. We also observed that some contractors are working as frequently and as much as full-time faculty, despite contract language stating that such medical services are needed only on a "part-time or intermittent basis".

The Medical Director at KDMC told us that specialists (particularly radiologists) are difficult to hire and recruit for several reasons. These include KDMC's location, the current negative media environment surrounding the hospital, and rates of specialist compensation that he described as below-market. The Medical Director also attributed high utilization of contract radiologists to the closing of KDMC's radiology residency program, which reduced the number of staff in that specialty area.

The Medical Director stated that there were times after the radiology program closed when contract physicians provided the only on-site coverage, particularly at night and during weekends. He attributed the large number of hours reported by contract physicians to this "crisis" in staffing. We confirmed the number of staff radiologists declined significantly, and now stands at seven faculty doctors, including the Interim Department Chair. An examination of productivity measures provided by KDMC staff shows that the contract physician named in the Los Angeles Times article performed more "work" than many other contract or faculty radiologists. However, these productivity figures were not always proportionate to the volume of hours he claimed.

This variance might be explained by the fact that this physician worked shifts when there was a lower volume of work to complete. However, a Reliable executive acknowledged that the doctor also may have been sleeping during portions of some shifts for which he claimed time. We noted both Reliable and DHS fiscal staff questioned some of the doctor's invoices that claimed consecutive 24 hour shifts to verify they were accurate. The invoices were subsequently paid as billed, and we could not find any evidence that Reliable acted improperly.

A Reliable executive confirmed that radiologists are in very short supply, and told us his firm often had difficulty providing enough contract physicians to meet operational needs at KDMC. Consequently, available contractors were frequently asked to work additional shifts. The Reliable executive also cited many of the same reasons as KDMC's Medical Director for having difficulty hiring contract radiologists to work at the hospital. The executive also told us that other clients, such as Kaiser Permanente, pay significantly more per hour for radiologist services than DHS, place fewer restrictions on the terms of contract physician employment, and impose fewer controls over time and attendance.

During our interview, the Reliable executive told us that the contract physician identified by The Times was also employed as Reliable's Medical Director while providing contract services at KDMC. According to the executive, this contract doctor solicited new physicians to join Reliable's registry, and was responsible for scheduling contract

radiologists at KDMC. This placed the contractor in a potentially conflicted position, as he could have scheduled the shifts of other contract staff to his benefit, though we found no evidence that he did.

We noted that many of the contract radiologists in our sample, including the contract physician noted above, are former KDMC employees or internists who left County service to work for contractors. While the decision to pursue contract rather than full-time work was likely driven by greater earnings potential and scheduling flexibility, it could not have been beneficial for faculty retention that a KDMC contract radiologist also worked as a recruiter for Reliable. However, clinical management would have had no way to know this because DHS does not expressly require contract staff to report outside employment activity. Instead, physician contracts require compliance with conflict of interest laws, ordinances and regulations, and mandate that contractors report conflicts, in writing, to the Director.

To address the ongoing shortage of radiologists, particularly at night and during weekends and holidays, KDMC recently entered into a short-term contract with Rad-Image for the provision of Nighthawk Teleradiology Services. This service operates by transmitting a digitized image of an x-ray or radiograph to a qualified offsite physician for analysis and review. The service is available when staffing levels are lowest, between 7PM and 11AM, seven days per week, including holidays. This allows health centers and hospitals with staffing limitations to continue functioning, even in the absence of an onsite radiologist. DHS is currently in the process of negotiating a longer-term contract with Rad-Image to continue these services beyond the pilot period.

Oversight and Control Procedures

Responsibility for overseeing specialty medical services agreements is shared between clinical administrators, who supervise line operations at DHS facilities, and fiscal staff, who review and process contractor invoices for payment. Clinical administrators, including Department Chairs and/or the facility Medical Director, review contractor time records and certify that hours claimed were actually worked. Hospital fiscal staff then examine time sheets and corresponding contractor invoices for computational accuracy and compliance with contract terms and conditions such as work hour maximums for exempt contracts and rates of compensation. Invoices are then returned to clinical administrators for final authorization to pay, after which fiscal staff initiate payment via CAPS. With minor variances, this procedure is generally followed when processing all registry and contract physician invoices.

Processing and payment functions were transferred from KDMC to Rancho Los Amigos National Rehabilitation Center (Rancho) in March, 2004 as part of the ongoing re-organization at KDMC. This has resulted in an additional layer of review for computational accuracy and contract compliance. We noted that Rancho staff have also taken an active role in questioning contractor invoices that do not appear reasonable or consistent with past work patterns. While sometimes delaying payment to the contractor, this has increased accountability over contractor billings.

When we initiated our review, we requested a comprehensive list of all Proposition A and exempt agreements from DHS management. However, the list we received from the Department's Contracts and Grants Division (Contracts) did not include every contractor. Contracts staff subsequently informed us that their database may not be reliable, and is not always updated timely to reflect new contracts or to remove agreements no longer in effect. As a result, some Contracts staff maintain their own spreadsheets of active contracts. We eventually reconciled the list provided by Contracts with additional data from fiscal managers at KDMC, Rancho, and other facilities to create what we believe to be a comprehensive register of contract physicians for this review.

We noted that many of the hours billed by contract staff are certified as accurate by clinical administrators who are not physically present when the contractor claimed to have worked. This places obvious limitations on the extent to which KDMC managers can exercise meaningful oversight of contractor attendance. For example, a KDMC administrator responsible for APG contract physicians told us that timesheets are certified by comparing hours charged with the most current anesthesiologists' work schedules. Variances between hours reported and scheduled are then investigated.

We observed that this form of "review" does not offer any meaningful verification that hours reported by contractors (or faculty) are accurate. The administrator responded that other hospital employees would "notice and complain" if an anesthesiologist was not present when scheduled to work. Therefore, he believed the review system was adequate. While we did not find any evidence that anesthesiologists or other contract physicians were misreporting their time or claiming hours not actually worked, existing oversight mechanisms are of limited value.

By necessity, large hospitals are twenty-four hour operations, with staff providing critical services day and night. In such an environment, no single administrator or Department Chair can realistically or effectively certify the attendance of all staff, whether contract or faculty. To address these limitations, we have recommended that DHS immediately establish more meaningful controls over contractor work hours and require contract physicians to disclose outside business/employment activity as a term of their agreements. Specifically, DHS should immediately direct hospital managers to require that contract physicians obtain independent verification they were present when scheduled. This could be accomplished by the hospital designating an employee, who was actually present when the contractor was working, provide an approving signature on each claim. To the extent possible, the authorizing employee should be in a position to observe the contractor's performance.

Conclusion

Overall, we believe that there is a legitimate need for contract physicians to meet staffing demands and to provide necessary care and services to patients at KDMC. However, one of the most significant obstacles to effective oversight of specialty medical services agreements is the absence of independent verification that contract doctors were actually present when they claimed to be working. The importance of

such verification is increased by the fact that some doctors have private practices or other secondary employment outside the County, which could result in hours not worked in County hospitals being billed to the County if working hours are not closely monitored. This problem is compounded by the absence of any requirement that contractors report outside employment activity.

To strengthen controls over contractor timekeeping, we recommend DHS immediately require independent verification that contract physicians were present when scheduled. This could be accomplished by the hospital designating an employee, who was actually present when the contractor was working, provide an approving signature on each contractor claim. To the extent possible, the authorizing employee should be in a position to observe the contractor's performance.

Other Issues

Potential Conflict of Interest (Moonlighting)

We identified one case from our sample population in which a KDMC staff radiologist was concurrently employed as a Reliable contractor. We compared this doctor's time records from the County Wide Timekeeping and Payroll Personnel System (CWTAPPS) with invoices she submitted for work billed via Reliable. We found several instances where the doctor reported working full shifts at KDMC (at least eight hours each) on the same dates she billed the County for contract services.

This doctor appropriately reported her outside employment activity on her annual declaration, as required of County employees, and we noted that DHS does not have a prohibition against hospital staff moonlighting at the same facility where they work. We also did not find any evidence this doctor double-billed or simultaneously claimed working in both staff and contract capacities at KDMC. Nevertheless, allowing such dual-role employment at one hospital raises serious questions as to the potential for a conflict of interest. Specifically, such an arrangement might cause dual-role staff to delay their processing of x-rays during County work hours to justify increasing contractor staffing levels, thereby providing a financial incentive to be less productive. To address this issue, we recommend the Department establish work performance standards, particularly for dual-role employees, and work with County Counsel to determine whether such dual-role activity can or should be more closely regulated/restricted.

In addition to our analysis of contractor work hours and shifts, we also conducted a search of public records via Lexis-Nexis to determine the extent to which registry and independent contract physicians had other outside employment. Information we found indicates that a number of contract doctors are affiliated with other medical institutions or hospitals, have private practices, or are involved in outside business ventures. In addition, recent audits have also identified cases where faculty physicians claimed hours not actually worked, including while moonlighting at a private practice, suggesting that such activity could also be affecting demand for contract staff. However, because DHS does not expressly require contract doctors to disclose their outside employment

activity, Department management and hospital administrators would have difficulty determining whether it presented a potential conflict.

DHS should require contract physicians to disclose outside employment and business activity as a term of their agreements with the County. The Department should also ensure that faculty is appropriately reporting hours worked, and that outside employment declarations are monitored for potential conflicts.